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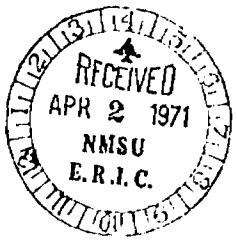
ABSTRACT

The 1961 booklet is the report of a 2-year study of mental health problems and needs of Mexican Americans in one area of San Antonio, Texas. The Good Samaritan Center in San Antonio and the Division of Mental Health, Texas Department of Health, conducted the study as part of an effort to develop a project of preventative services. According to the report, Mexican Americans constitute approximately 15 percent of the total population of Texas. Concentrated largely in the southern half of the state, they constitute over 50 percent of the population of that area. The report is divided into 4 main sections: (1) Neighborhood Characteristics, (2) Children and Their Mental Health Needs, (3) Health Factors and Family Relationships, and (4) Considerations for Service. Included in the document are 2 appendices: (1) Case Selection and Interviewing and (2) Bibliography of Related Studies. (EJ)



The Forgotten Egg

A study of the mental health problems of Mexican-American residents in the neighborhood of the Good Samaritan Center, San Antonio, Texas.

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CONTENTS

FOREWORD

People of Mexican descent constitute a substantial proportion (estimated 15 percent) of the Texas population, and are largely concentrated in the southern half of the state. Here they make up half or more of the total population.

Evidence to date has not shown that mental health problems among these people are greater or lesser *in extent* than among the other 85 percent of the population. Yet relatively few have been seen and even fewer successfully treated in the community mental health clinics as compared with other population groups. It is obviously important to learn more about the nature and extent of mental health problems of Mexican-Americans and ways in which effective preventive measures can be taken.

The Texas Department of Health, as the state agency responsible for preventive services in mental health, has, through the Division of Mental Health, been searching for and testing new and productive community approaches in prevention. Such approaches have been tested through three so-called pilot projects, where a community has been helped to establish a new pattern of mental health services. Evaluation of the effectiveness of each has pointed the way for other communities to undertake similar services.

A project providing preventive services to Mexican-Americans has long been sought. Through the initiative and interest of the staff of the Good Samaritan Center, a multiple-purpose agency serving a Mexican-American neighborhood in San Antonio, planning has been under way for over seven years.

To develop a sound project plan, the first need was to learn about the neighborhood, its people, the mental health problems they have, their awareness of these problems, and enough of their patterns of seeking help with their problems to serve as a basis for designing preventive services.

This report describes the study that has gone on during the past two years and outlines possible service patterns. It represents the work of Mrs. Constance Swander, director of Good Samaritan Center, and three staff members of the State Health Department's Division of Mental Health, Dr. Wallace Mandell, psychologist (now director of research of Staten Island Mental Health Society, New York); Miss Ila Fern Warren, consultant psychiatric social worker, and Dr. Fred Crawford, sociologist and research consultant for the Division. Invaluable assistance was provided by the San Antonio Health Department nursing staff as well as staff of the Good Samaritan Center. The principals and first grade teachers of Carvajal and Sarah King elementary schools were similarly most gracious in giving their time and knowledge for the study.

From the learning reflected in this report and from further study and planning now in process, it is hoped that a pilot project extending over five to ten years can be established soon. Not only San Antonio but other communities in Texas and elsewhere thereby may find effective methods of preventive intervention among Mexican-American families to reduce the prevalence of emotional disorders in this significant population group.

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11-2-61

MAL OJO

(Evil Eye)

Among Mexican-Americans, social relationships are believed to carry inherent dangers. Both young and old are susceptible to the virulence of mal ojo, which develops when persons possessing "strong power" gain unusual control over "weaker" persons. The eyes are the apparatus involved in causing this illness – strong glances, covetous expressions, and excessive attention. The person afflicted with mal ojo loses the "will to act," becomes lethargical and despondent. Many women of Mexican descent understand the causes and treatment of this illness.

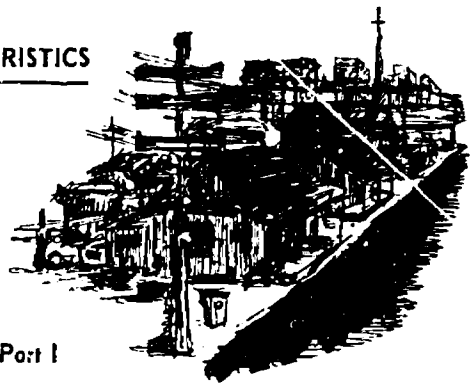
To treat mal ojo, the victim's warmest relative (mother or grandmother) takes a hen's egg and rubs it over the patient's whole body to absorb some of the heat and evil power. The egg is next broken into a water glass half-full of liquid. The shape of the egg as it settles into the water determines not only the diagnosis of mal ojo, but also points out whether the person causing it was male or female.

Once the diagnosis has been made, the egg-water mixture is placed under the head of the patient's bed, remaining there throughout the night. By morning, the mysterious draining powers of the egg are presumed to have drawn the evil power from the victim's body, and the cure is complete.

(This is a paraphrase of a complete description of mal ojo developed by: Arthur J. Rubel, "Concepts of Disease in Mexican-American Culture," American Anthropologist, Vol. 62, No. 5 (October, 1960).

SECTION A

NEIGHBORHOOD CHARACTERISTICS



Part I

Heritage and Change

The Texans of Mexican origin represent a rich and complex culture that traditionally has resisted adopting many elements of the Anglo way of life which predominate in this state. In 1950, at least 39 percent of the residents of San Antonio were Mexican-Americans. Although immigration from Mexico to Texas continues, the majority of the Mexican-American citizens in San Antonio are native born citizens of the United States. In fact, many of these families can trace their ancestry back to the original settlers in Texas who followed the Spanish soldier-explorers and priests.

The impact of World War II upon the Mexican-American was perhaps more disturbing in many ways than it was upon the Anglo-American. From the relatively isolated ranches, villages, and even neighborhoods of urban areas, the Mexican-American male was called into service, trained, and fought along side his Anglo-American brothers. The glimpse of a more equal existance, plus the opportunities afforded by the G.I. Bill, worked together to bring about some changes in traditional ways of life. Some of these changes led to further education, to migration into urban centers in search of better jobs, to home ownership, and to modifications of the ideal paternalistic family pattern which has been characteristic of much of the Catholic-Mexican population down through the years.

The neighborhood which forms the basis of this study is located in the southwest section of San Antonio near the western boundaries of the city. In 1945, a lumber company began the development of this area by building a number of small, wooden houses. These dwellings were constructed without facilities for water, sewage disposal, or electricity. There were no paved streets.

The large number of Mexican-American veterans seeking homes plus the opportunities for employment afforded by the two large military installations nearby facilitated an influx into this area so that by 1950,

there were 9,700 people living here. In the meantime, the city began to bring in a few water and sewer lines. But with the scarcity of these facilities, tremendous health problems developed. The area was included by the city health department in a segment known as "death's triangle" because of the high infant and maternal death rates as well as the high incidence of, and mortality from, tuberculosis. There were no health and welfare agencies located in the neighborhood and problems were multiplying.

In 1950, an elementary school was built in the area, and in 1951, the Good Samaritan Neighborhood Center was opened. Also at about this time, a public housing project providing facilities for 350 families was built. The health department cooperated by establishing clinics at both Good Samaritan Center and the public housing project. In 1953, a general medicine clinic was started at the Center.

Since 1951, two additional schools (one elementary and one junior high), three churches, and a second public housing project have been constructed in the area. In 1960, a fourth church was being built. The estimated population of the neighborhood in 1960 was 16,000.

Some of the streets are now paved and curbed; street lights are installed at every other intersection in most of the area; and many, but not all, homes have connected with water and sewer lines. Private developers have also opened up a large area to the south of the Center known as Brady Gardens. The physical transformation of the neighborhood has been sudden and dramatic, if not complete.

Along with the physical transformation of the neighborhood, there have occurred changes in traditional ways of doing things and life styles. One fact cannot be overlooked in this general situation: The Mexican-Americans in Texas do not constitute a homogeneous population in terms of any one cultural characteristic or even of any complex of characteristics. There is within this population as wide a range of cultural values as may be found among the Anglo-Americans and an equally wide range within any single cultural characteristic.

All Mexican-Americans are not poor; all do not speak Spanish; all are not uneducated; all are not dirty; all are not in poor health. The same *ranges* of poverty—wealth; or ignorance—understanding; good health—poor health; apathy—ambition; objective behavior—superstitious behavior; religion—anti-religion; and so forth, exist among the populations of both Mexican and Anglo-Americans. Some of the obvious differences are related to the concentrations or proportions of one or the other populations at points along these ranges. In other words, there is undoubtedly a larger proportion of Mexican-Americans than of Anglo-Americans who are poor, who do speak Spanish, who have poor health, and so forth; but there are also many Anglo-Americans who have these same characteristics singly if not in combination.

As the description of the residents in the Good Samaritan Center's neighborhood is expanded in the following pages, some of the changes in

traditional ways of doing things by these people will become more obvious to the reader.

Part II

Origin of this Study

In the fall of 1954, informal conferences began between representatives of the Good Samaritan Center and the Division of Mental Health, Texas State Department of Health. These meetings were initiated by the staff of the Center out of concern for the mental health problems which they observed. The agency staff needed help in developing better understanding of these problems, and in finding the most appropriate ways of providing services to meet them.

The traditional community guidance clinic has experienced difficulty in working with people of Mexican descent even when staffed with Spanish-speaking personnel having a fairly comprehensive understanding of the cultural factors involved. The reasons for this inability to work successfully with Mexican-Americans have not been clear. Based on the philosophy of the neighborhood center that "when people need you, they need you near," agency staff originally assumed that a clinic located in the neighborhood and associated with other service programs familiar to the people of the area might be more successful than a clinic located outside of the neighborhood. Most clinics in San Antonio are centrally located and in a "strange and unfamiliar" setting to residents of relatively isolated neighborhoods. Public transportation facilities serving areas on the periphery of the city are slow in moving passengers to and from the central city, and also expensive in terms of the income received by many of these families.

The first conference concentrated on finding staff and working out details for a neighborhood-centered guidance clinic. Problems of staff, budget, recruitment, and office facilities continued to interfere with the feasibility of this plan although interest remained and conferences continued for approximately five years.

During this period, the staff of the Center and of the Division became increasingly convinced of the general lack of knowledge among professionals concerning: (1) the emotions and information which the Mexican-American residents have concerning problems which by Anglo-American standards are considered to be in the mental health field; (2) the kinds of behavior which are disturbing to Mexican-American families; (3) the resources currently used by Mexican-American families for help with such problems; and (4) the most appropriate type of service to be offered to residents of this neighborhood.

Late in 1959, the two organizations agreed that they would begin a period of study which hopefully would lead to clarification of these ques-

tions not only for the residents in this neighborhood but to similar groupings of Mexican-American citizens throughout Texas. The basis for the joint effort between the two organizations lay in their mutual concern for adequate knowledge regarding effective methods for rendering to people of Mexican descent services which would assist in developing sound mental health and in preventing mental illness.

After considerable thought and planning, the decision was reached to concentrate upon the problems of children in this neighborhood. Specifically, the children who were involved in the common experience of adjusting to the first grade in public school were singled out for study. All of the teachers of first grade children in schools located in the Good Samaritan neighborhood were interviewed about all children on their class rolls. A special group of 24 children was selected from this total for a closer examination of the family aspects involved in the presence (or lack) of problems in school adjustment.

The public health nurses serving the residents in the neighborhood were also interviewed concerning all cases they had on their caseloads where there was any indication of mental or emotional disturbance in the family. And finally, the records of the clinic at the Good Samaritan Center were used to obtain basic information about the kinds of persons served and their problems. A full description of these sampling and data gathering techniques is presented in Appendix A.

The specific questions, stated briefly, around which the study was finally designed are as follows:

(1) What are the characteristics of this neighborhood and its people?

(2) What kinds of mental health problems are found among first grade children, and are these recognized as problems by the parents of such children?

(3) To whom do these residents turn for help with such problems at the present time?

(4) What cultural factors influence the development and treatment of emotional and mental problems in these children?

(5) What kind of service could be rendered by the staff of the Center, or cooperatively with the Division, to promote more effective service in the area of prevention of severe problems of mental health and more effective treatment where such problems have already reached the proportion which indicates need for help?

And from this beginning the search was started which led to the "Forgotten Egg."

Part III

Social Characteristics of the Neighborhood

As far as can be ascertained, there are extremely few non-Mexican-Americans who live in this area. There is, however, wide variation in the degree of acculturation and the length of time these families have lived in the United States. A few newcomers from Mexico moved directly to this neighborhood because of connections with relatives or friends.

That this is unusual is indicated by the experience of a ten-year-old in one such family who entered one of the neighborhood schools. Shortly after he joined his class, the other boys nicknamed him "Mexico" because he spoke no English and did not know anything about "how we do things."

Most of the children who attend activities at the Center are at least third generation Texans. This does not necessarily mean that their families have adopted "Anglo" ways. Usually, prior to moving into the neighborhood, these families lived in a Spanish-speaking community; often the mother and grandparents speak only Spanish and have had little or no exposure to the Anglo culture. Almost all of the interviews with the 24 families selected for special study were conducted in Spanish, although this was neither scholastic Spanish nor Spanish as spoken in urban Mexico. Three of these mothers spoke no English at all; two had taken courses in English at the Center; and the interviewers were uncertain as to whether or not the remainder of the mothers really could speak English.

Many of the males (fathers, husbands, and single men) in this neighborhood do speak English, and of course, many of them did serve in the Armed Forces. Children are taught English in school (where all teaching is conducted in English), and some of the children attended pre-school classes to help them gain a grasp of this, to many of them, foreign tongue.

A. Family Characteristics

The families in the Good Samaritan Center neighborhood are fairly large and the average number of persons per family is larger than it is for the United States as a whole. The gross average for the estimated 3,156 family units is 5.1 persons. (The U.S. average is about 3.7 persons per family.) Data gathered through the various survey techniques could be broken down into the following approximations: (A) the special sample of 24 families—8.4 persons; (B) 128 families in the records of two public health nurses—5.5; (C) 160 families which had received medical services through the Center's clinic during the first three months of 1960—6.8 persons. The ranges for family size reported for the latter two samples were from 1 to 15 persons. In sample (A), three persons comprised the smallest family while 12 was the largest size reported. A fourth sample (D) of all first grade school children was taken as part of the study but size of

family was not one of the items of information obtained from the teachers. (See Appendix A for a discussion of these samples.)

Information concerning the marital status of families was available from Samples (A), (B), and (D). In the descriptions of families provided by the teachers of the first grade students (Sample D), only 70 percent were reported as having parents who were married and living together. The public health nurses reported 84 percent of their cases (Sample B) had parents who were married and living together; and the special sample of 24 families (Sample A) contained only one case in which the parents were not married and living together. The mother in this one case had died of cancer.

Problems pertaining to adults who were without spouse; who were separated; and who had produced children out of wedlock, were more in evidence as reported by respondents in samples (B) and (D) than were conditions of widowhood, divorce, or desertion.

It is still generally true in the overall picture of these families that strong traditions of Catholic-Mexican culture relating to family life are held to be right and ideal, although they do not appear to be practiced extensively. For example, although the Mexican family is considered to be traditionally a patriarchal family (father centered), a great deal of responsibility was identified through the interviews as being left to the mother while the father often stayed aloof from the many details of family life. He also may enjoy a separate social life with his male friends. His relationship with his children is not always a close one, although changes in this pattern plus some suggestions as to the importance of father-child relationships will be presented later.

In an interesting informal discussion between the Executive Director of the center and two women who know the neighborhood, the importance of the father as head of the family was brought up for discussion. The immediate response of Mrs. R. was:

"Oh no, that isn't important. It is only important that you make him think he is. Sometimes you have to be deceitful."

Mrs. L. stated that most Mexican mothers leave the discipline of boys to the father. The mother may discipline the girls on minor things but she "complains to the father" and lets him take care of discipline of anything serious. A description of discipline patterns as revealed through the interviews with the 24 families selected for special study will be presented later in the descriptive material.

Mrs. L. also indicated that most Mexican families are very permissive with children when they are quite young. The period of rigid discipline comes when the boys reach eight or nine years of age; with the girls, usually at 10 or 11 "when they start to notice boys." Since this period of permissiveness extends beyond the time when the children start the first grade, Mrs. L. thought that "everyone is scared when the child starts to school." She also related that in most instances the father in the family handles the money and pays the bills. This statement was

contradicted by other people in the neighborhood who said that the opposite was true—the husband turns over all the money to the wife and she doles out what he needs for his personal expenses. Thus, the range of possibilities becomes manifest in this, as in all other, characteristics of family life.

The "respect relationship" which the anthropologist Oscar Lewis has described as prohibiting the discussion of any intimate matters between Mexican mother and daughter does exist in this particular Mexican-American neighborhood. Interviews with mothers such as Mrs. L. as well as other staff experiences and the problems concerning sexual adjustment in marriage revealed by the interviews with the various samples of respondents all point to this prohibition.

The dating practices of the neighborhood differ from those usually found in Anglo-American neighborhoods. In this area, the boys do not call for girls at their homes but meet them at club meetings and parties at the Center, or at movies and stores or other centers of social activity. When a boy calls for a girl at her home, it is considered to be an indication that he is ready to ask for her hand in marriage. When a couple marries, it is the custom for the newlyweds to live with the girl's parents. One of the changes is away from this practice. More and more young couples are expecting to start out living alone in their own homes. The groom usually still does buy the bride's wedding clothes; he also pays the cost of the wedding. This particular custom is more common among the families with some economic standing rather than among the very poor.

It is quite common to find that the Mexican-American woman feels very resentful towards her husband when she becomes pregnant, although she does not appear to feel any resentment towards the child. To the contrary, great affection and attention is centered on an infant and he remains the center of attention until the next baby arrives.

B. Religion

The predominant religion of the residents of this neighborhood is Roman Catholic. A small percentage of the total, although the second largest proportion, claim membership in the Pentecostal Church. One of the characteristics of this neighborhood is the large number of persons who, although they were baptized in the Roman Catholic Church and feel very strongly bound to it, never attend church, have not been confirmed, have not had any instruction in their religion, and do not marry in the Church. The priest stated that there were only about 250 out of 1,000 Roman Catholic families in which some members attended mass fairly regularly.

To the contrary, the members of the Protestant church seem to have a strong sense of belonging and mutual responsibility. Many of the women refer to other women in the Protestant congregation as "mis hermanas en Dios" (my sisters in God). It should not be forgotten that absenting one-

self from a Roman Catholic church and breaking away entirely to join a Protestant church are quite distinct. Perhaps this is the reason for the closeness of the members of the Protestant group—having experienced a certain amount of ostracism socially, they must then make the present tie even stronger to offset this feeling of general rejection.

C. Education

There is little evidence available which could be used to clarify any changes regarding the education of Spanish-name adults in San Antonio as reflected by the 1950 census data. This census showed the average grade completed to be 3.5. These figures undoubtedly have been modified upwards somewhat by the new young adult population which has moved into the Brady Gardens area in recent years. With the children the picture is changing rapidly. In May, 1960, 200 children were graduated from the local junior high school, and it is estimated that nearly twice that many will be graduated in May, 1961. About 20 teenagers known to the Good Samaritan Center staff graduated from high school in the spring of 1960 and several are currently in college.

In the 1959-60 school year, a total of 2,146 children between the ages of 6 and 12 were enrolled in the two elementary schools which cover the major share of this neighborhood. An additional 42 were in parochial school, and 34 were in special schools including the play therapy classes at the Center.

According to figures from the school census of 1960, there were 2,448 children in this age group living in the neighborhood. Consequently, there are an estimated 226 children of elementary school age who are not attending any school.

Of the children enrolled in the two elementary schools, approximately 100 enroll late and leave early to accompany parents who "go North" as migrant agriculture workers.

D. Occupation and Income

No effort has been made to secure statistics on occupations of employed persons but certain observations of staff may be helpful. There is known to be a wide variation in types and regularity of employment. These exist within the positions of the neighborhood: teachers police officers, postal employees, clerical, and other skilled workers who are employed both at military installations and in private business and industry. There are also many unskilled laborers who work as helpers in the construction trades, laboring jobs at the produce markets, and yard work. The degree to which weather conditions affect income in families is an indication of the dependence on irregular and unskilled work.

A study of a sample of 160 families (Sample C) receiving care in the Good Samaritan Center clinics during the first three months of 1960 showed that 63 percent of the families had incomes of less than $200 a

month. On the other hand, the income of 40 families who applied for admission of a child to kindergarten ranged from $120 to $500 a month with an average monthly income of $263. Fourteen families out of 40 had a monthly income of $300 or over. Similar data were not obtained for the other samples.

Other indices such as studies of the distribution of families receiving public assistance and medical care in public clinics indicate that the area is essentially one of low income.

E. Health and Medical Care in the Area

On the subject of health and medical care, one of the most important things which has happened in the neighborhood is the reduction in the number of cases of infant diarrhea and infant deaths resulting from this and other causes. While the total population of the neighborhood constitutes 2.7 percent of the population of San Antonio, births are 3.4 percent of the total and the number of infant deaths constitutes only 2.2 percent of the total for the city. These figures were taken from the City Health Department for the first quarter of 1960.

Tuberculosis has also been a tremendous problem in the neighborhood and is still. There are very few figures on this, but it is known that a special clinic has been set up at the Cassiano Housing Project for outpatient treatment of tuberculosis patients, which would indicate a recognition of this recurring problem. The people, also, are realizing the necessity for treatment as larger numbers are being treated.

The clinics held at Good Samaritan Center had had between six and seven thousand patient visits per year, and requests for medical care are increasing. In the beginning, only children were brought to the clinic for treatment, but lately an increasing number of older people have been coming. The treatment clinic is primarily a screening clinic which treats the acutely ill with upper respiratory infections, skin conditions, and diarrhea, etc. Of these illnesses, diarrhea continues to be the most predominant. Of the chronic illnesses, diabetes is the most recurrent. A more complete description of health problems will be presented in discussions of specific samples.

F. Health and Folk Medicine

One of the striking breaks with tradition has occurred in the reliance residents in the neighborhood place upon folk medicine. It is in this context that the "egg" takes on its symbolism because the egg is a key instrument of the folk-curer. Arthur J. Rubel has recently completed one of the most intensive studies of health concepts among Texans of Mexican heritage in the Rio Grande area. It is his contention that there is little clear distinction between illnesses of a mental and physical nature in the beliefs of these people.

There are also five distinct illnesses found to be present among Mexican-Americans which are not found among Anglo-Americans. These are: (1) *caida de la mollera* (fallen fontanel); (2) *empacho* (food blocking the intestinal tract); (3) *mal ojo* (evil eye); (4) *susto* (shock); and (5) *mal puesto* (sorcery). The first four illnesses are considered to be *males naturales* (sickness from natural causes). These all lie within the domain of God. *Mal puesto* is an illness *artificial* and lies outside the realm of God (i.e., is the work of evil sources or the devil). The folk healers, whether they be wise members of the family or specialists of which there are many different kinds, all are thought to be able to cure these illnesses.

In curing *mal ojo*, for example, the healer takes a hen's egg and rubs it over all of the patient's body to absorb some of the heat and power which has disturbed the balance of the child (although adults can also be the victims of *mal ojo*). The description of this treatment was presented as an introduction to this report.

The belief is that *mal ojo* stems from the ability of one individual with "strong power" to over balance the equilibrium of the "weaker" person through social relationships. Thus women and children, being of weaker nature, are particularly susceptible to *mal ojo*. The interaction of children with the outside world—whether it be schools, activities at the Center, or other contacts—vividly suggest the breaking down of the fears surrounding *mal ojo*.

Another illness which is more clearly identifiable as falling within the mental illness category is *susto*. The symptoms, as reported by Rubel, are: "long continuous periods of languor, listlessness, and lack of appetite." The causal experience may be something of a frightening nature, or just the reactions of the ill person to the vexations and problems of everyday social life. *Susto* comes about when the *espiritu* leaves the body; many older women seem to know how to cure simple *susto*.

The concepts and beliefs concerning the use of "hot" and "cold" elements in the treatment of these illnesses point back to the early Greek concepts of illness and cure, which probably came into Spanish culture through the influence of the Moors during their sojourn in Spain up until 1492. From Spain these beliefs were carried to the New World and handed down from generation to generation. Today, these beliefs are being modified and discarded.

Rubel concludes: "The pathologies. . .are an area of high anxiety for all sectors of the Mexican-American population. Those whose orientation is toward adoption of Anglo-American socio-cultural behavior—particularly those persons who are now attending, or have once attended high schools together with Anglo-Americans—tend to disparage these concepts of illness as ingenuous beliefs, survivals of an unsophisticated past. The more credulous, on the other hand, seize upon every available opportunity to vouch for the authenticity of the illnesses."

The staff at the Center have been very aware of these health beliefs and changes which have occurred over the past several years. Although

diminishing, there is still a very widespread and deep-seated conviction on the part of some residents in the neighborhood that there are special causes and cures uniquely part of their folk medicine. It is quite interesting to note that many patients come to the Center for modern medical treatment, while at the same time enlisting the services of a *curandero* (one type of folk healer) or using other folk remedies which have been tradition in their families.

Emotional problems in particular are still frequently traced by the patient to *mal ojo* or *susto*. The specialized healer of *susto*, particularly *susto pasado* (an extreme form which, if uncured, can result in death) is known as a *curo de susto* and holds special status.

Four cases in point are:

- Mr. R., who drinks heavily, beats his wife and children and insists upon sexual relationship with his wife at any hour of the day or night without regard to the number of children resulting. He is not willing to seek help for his alcoholism and his wife believes his behavior is the result of the "evil eye" put on him by a jealous woman.

- Mrs. M., who has a congenitally crippled child, believes she has this condition because the "evil eye" was put on the family before the child's birth.

- Mrs. S., whose thirteen-year-old daughter died of shock at the death of her father, believes this was the result of *de susto*.

- Mrs. T., who heard voices which told her to do all kinds of things which she really didn't want to do, was unable to help herself until the curandero gave her powders to sprinkle around the room to keep the evil spirits away.

Many people say that they do not really believe this, but then proceed to give numerous examples of situations in which the cause and cure of illness was "obviously in the realm of magic."

A public health nurse conducting an interview with one of the mothers in the special sample of 24 families recorded the following:

Nurse: "Was the baby ill yesterday?"

Mother: "Yes. You know, we Mexicans don't go to the doctors unless we are real sick."

Nurse: "What did you do?"

Mother: "She loves canna leaves so I took mentholatum and rubbed her and then took these leaves and wrapped her up completely. These leaves are very cool and they reduce the fever."

Nurse: "The leaves relieve the fever?"

Mother: "Yes, they are cool. You wrap her in them, but before you do, you make a paste of mentholatum and aspirin."

Nurse: "Did it work?"

Mother: "Yes. In a half hour her fever was gone. I had some relatives visit from Monterrey and they saw me doing this and were scandalized. They said they hadn't seen such doings—that we should take her to the doctor immediately. I told them I tried things like this baraja and higuerin leaves. If the child doesn't get better in two or three hours, I take them to a doctor."

Nurse: "Where did you learn these remedies?"

Mother: "Oh, I learned it from Mrs. G. She is from the interior of Mexico and she gives me these remedies. She says that where she comes from, 'a stranger is not allowed. . .' After I got married and was married for seven years before I had children, and we started going out to the fields to work and there were no doctors, I had to do something. Believe me, I tried everything when the children got sick. Now the neighbors around here are coming to me to get the different herbs. I have them all growing in my yard. Now when my mother comes to visit, she teases me about all my herbs and says, 'Uh huh, and you didn't use to believe; you were always calling me a *yerbera*'."

But this pattern is becoming more and more unusual as these mothers learn the value of modern medicine. And thus, the "egg" is being forgotten as favorable experiences with physicians and clinics continue to occur.

SECTION B

CHILDREN AND THEIR MENTAL HEALTH NEEDS

Part I

399 First Graders as Seen by Their Teachers

In the interviews with first grade teachers about their students (Sample D), the incidence and magnitude of disturbances and needs known to exist in these young lives was startling. Although the direct objectives of the interviewing were to obtain information about the presence of emotional disturbances, rich data concerning physical health and family characteristics were also obtained. These will be discussed in the descriptive materials in Section C.

A. Mental Health Needs

Of the 399 children discussed in the teacher interviews, 257 had identifiable needs and 142 had no unusual difficulties according to their teachers. This incidence count refers only to the presence of difficulties—not to the *degree* of the difficulty in the child's life.

Taking now only those 257 children with identified needs, a total listing of 464 separate difficulties could be identified. All of these disturbances were grouped, by the researchers, into seven categories as follows:

I.	Retained child	13% of disturbances
II.	Suspected mental deficiency	2% " "
III.	Conduct disturbances	47% " "
IV.	Special symptom reaction	20% " "
V.	Complaints involving emotional distress	14% " "
VI.	Immaturity (for age group)	4% " "
VII.	Other	1% " "
	Total:	101%

The largest number of difficulties was identified as being "conduct disturbances." "Special symptom reactions" ranked second, followed by

complaints involving "emotional distress" and the problem of being "retained" in the first grade.

The average number of difficulties for these 257 children was 1.8. Fifty percent of them had two or more. Nineteen percent had three identified difficulties; and eleven percent had from four to six.

Within the category of "conduct disturbances," the greatest frequency occurred around "acting out behavior," indicating some overt difficulty between child and teacher, or child and other children. These problems included inattention in class; failure to follow instructions; personal frictions; fighting, arguing; stealing; destructiveness; lying; cheating; biting and scratching; and the use of bad language or signs. Twenty-seven percent of all the difficulties fell into this sub-category.

"Withdrawal" was also listed under "conduct disturbances" and fourteen percent of all problems were of this type. Here was listed the shy, timid, and bashful; the daydreamer; the child who would not respond; the stubborn child; and the child with overt symptoms such as sucking thumb, fingers, or fist.

Inconsistent school attendance did not seem to be a frequent problem for these children and only four percent of all difficulties were of this nature. Learning difficulties were reflected not only in the thirteen percent of cases involving failure to pass to the second grade but also an additional six percent with inabilities to grasp the knowledge presented in the classroom.

Twelve percent of the disturbances were related to speech difficulties and handicaps such as lisping, baby talk, stuttering, and use of English. While these disturbances were classified separately, there is a close theoretical relationship between speech problems and emotional distress. Four specific types of emotional distress were reported: worry, depression, nervousness, and persistent fears or phobias (including crying). Fourteen percent of the total spectrum of difficulties fell into the emotional distress category.

What this brief description does is to point out that difficulties of many different kinds in the lives of these children were apparent to the teachers. Certainly this group of students, encompassing all first grade children on class rolls in the neighborhood, is completely representative of this age-academic group. Whether or not the presence and frequency of these difficulties is unique for this group of Mexican-American children, or similar to problems among other first grade children in the Anglo-American and Negro-American populations, is not known. Future inquiries of a similar nature among these other ethnic groups would be of great value, and would have to be done before any comparisons could be made.

Part II
Twenty-Four Families

A. Mothers View Their Children: Symptomatic Behavior

The high incidence of difficulties described by the teachers in their interviews concerning the first grade students led the study team to attempt a closer examination of the children in their family situations. In this special interviewing, answers to two major problems were sought: (1) Does a child's behavior which is considered to be symptomatic of potential mental health disturbance by specialists, bother parents in the Good Samaritan neighborhood? (2) And are there other things that these children do which bother the parents in this neighborhood?

From among the total sample of first grade students reported on in Part A, 24 cases were selected for special study (they comprise Sample A). Eight of these children were described by their teachers as "having no problems of school adjustment." The other 16 children were considered to represent varying types and degrees of problems. The actual selection of cases was constrained only by the effort to get a representation of as many types and degrees of problems as possible.*

Two public health nurses who were conversant in Spanish undertook the actual interviewing. Contacts were made with 23 mothers and the neighbor woman who kept the little boy "David" during the day while the widower-father worked.

1. *Recognition of Symptoms.* During each interview the nurses attempted to obtain the mother's interpretation of the child's behavior in eleven specific areas.** The lead question in each area of inquiry followed this pattern:

"Does your child show:"

1. Fears or night fears
2. Disobedience, talking back
3. Temper tantrums
4. Fighting and destructive behavior
5. Stealing
6. Fidgeting and restlessness
7. Wetting and soiling
8. Shyness and withdrawal
9. Masturbation
10. Storytelling, imaginary playmates
11. Somatic complaints—headache, stomach-ache, etc.

*For a description of the method of case selection and interviewing with the selected samples of families see Appendix A.

**The development of this list of symptomatic patterns of behavior is described in Appendix A.

A general question was also asked about any other problems in the child's behavior which bothered the mother.

> Finding: Mothers of these children were aware of and could describe, when questioned by the nurses, behavior which was considered by 4 experts to have serious implications for mental health.

a. *Symptoms Among the Sample Children:* The symptomatic behaviors mentioned most frequently by the mothers of the children with "school problems" were: (1) Somatic complaints—56%; (2) Fears and night fears—43%; (3) Wetting—37%; (4) Fidgeting and restlessness—31%; and (5) Temper tantrums—31%. In general, these mothers could describe such behavior when it had occurred, and also they could explain their attitudes and actions (if any) toward such behavior. The only two reported cases of masturbation occurred among the sample of "school problem" children. Almost all of the mothers indicated that this behavior would be very disturbing to them if they knew about it. No cases of soiling were reported by any of the mothers.

Almost all of the mothers also indicated that talking back and lack of obedience would be considered as disturbing behavior, although only 2 mothers in each grouping reported some difficulty with their child concerning this. Stealing, fighting and destructive behavior, and shyness and withdrawal, were also readily identified by these mothers as things they would be upset about if such occurred in their children's behavior. The only cases of stealing and fighting were reported by mothers of the "school problem" children. Four of the mothers in this sample group, and two in the "no problem" sample, reported some concern over their child's shyness and withdrawal tendencies.

The "no problem" children evidently did constitute somewhat of a different type of child in that their mothers reported *no* cases of fears, fidgeting and restlessness, fighting and destructive behavior, storytelling and imaginary playmates, masturbation, or stealing among them.

b. *Symptoms Among Other Children in These Families:* Frequently during the interviews, these mothers would make reference to the existence of the specific symptoms in the behavior of other children in their family. Because the questioning was not expanded (except by choice of the mother) into the situations involving other children, complete data were not obtained. The interesting glimpses into these families which did emerge were sufficient to stimulate an attempt at counting the frequencies of these reported symptoms.

First, each of the 24 children did have siblings (brothers and/or sisters). Second, excessive friction in interactions among the children in a family was reported by three mothers of the "school problem" children and only one of the "no problem" cases.

Mothers of the families with the "school problem" children reported the following among other children: three additional cases of fears or

night fears; one case involving obedience; one case of temper tantrums; one case involving stealing; one case of fidgeting and restlessness; two cases of wetting; and one case of somatic complaints.

The eight mothers in the families with the "no problem" children reported the following symptoms among other children in their families: three additional cases of fears or night fears; one case of temper tantrums; one case of fidgeting and restlessness; two cases of wetting; one case of masturbation; and two cases of somatic complaints.

This additional evidence, particularly from the mothers of the "no problem" sample, demonstrates again the individuality of the child in his adjustment to life, family, and school. The dynamics which existed around the "school problem" children *were not absent* from many of the situations in the homes of the children who had made satisfactory adjustment to the first grade. Also, two of the mothers from this "no problem" sample reported that other children in their families had had "problems" in their school adjustment.

The mothers of these 23 children plus the one neighbor were not only able, when this was discussed, to identify the specific symptoms which had occurred among their other children, but they were also able to describe the behavior and what they thought about it. On the basis of the available evidence, it can only be concluded that there were undoubtedly many other children "with problems" in these families who were not mentioned during the interviews.

2. *What the Mothers Did About Symptomatic Behavior:* There were interesting variations between the two samples of mothers in their reactions to the symptoms as well as in their attempts to "do something" about them. Three different patterns were discernible concerning reactions to some symptoms: (a) The mother said she simply ignored the behavior; (b) the mother said she attempted to exert control by punishment (or reward); and (c) the mother said she had sought help from some source outside the family.

The mothers of the families which had the "no problem" children sought outside help for wetting in the two cases for which this was reported. One of these mothers sought help for the somatic complaint of her child in the "no problem" sample; and the mother who reported that a sibling of a sample child masturbated also indicated she had sought outside help. The somatic problems mentioned for siblings in the "no problem" sample of families did not bring about attempts to get outside help.

The mothers of the families which had the "school problem" children usually did seek outside help for somatic problems. Outside help was also sought by these mothers for one case of wetting and three cases of fears.

Self-control items (obedience and temper tantrums) were the only symptoms for which punishment was reported by a few mothers from both sample groups. The mothers of the families of "no problem" children did not report punishing for wetting or any of the other symptoms. The mothers

of the "school problem" children did report cases of punishment for fighting, wetting (the usual method of handling this problem as reported by these mothers), and storytelling. This latter sample of mothers tended to ignore these symptoms: fears; obedience breaks; temper tantrums; fidgeting and restlessness; shyness and withdrawal; and masturbation.

The kinds and patterns of punishment used by the parents in these families varied in extremely different ways. In Section C, some elements of family dynamics, structure, and interactions, forms of punishment and reward will be analyzed.

B. Mothers View Their Children: Other Problems

During each interview careful note was made of any problem mentioned spontaneously by the mother concerning the sample child or other children in the family. Among the families of the "school problem" children, spontaneously mentioned concerns occurred in 69 percent of the interviews; only 37 percent of the mothers of "no problem" children expressed some concern spontaneously about a problem.

> Finding: The majority of these mothers spontaneously expressed concern about physical health, obedience, and school adjustment—in that order.

1. *Recognition of Problems:* The mothers of the two samples of first grade children differed in their expressed concerns in several important ways. First, the mothers representing the "school problem" sample emphasized physical illness and injury above all other problems. The health problems in these families, by inference, must have been much more severe than for the "no problem" families.

Secondly, in the interviews with the mothers of the "school problem" children most of the spontaneous discussion was directed toward the sample child rather than other children in that family. The reverse was true of interviews with the mothers of "no problem" children. Most of their statements of problems and concerns were directed toward siblings rather than the sample child. What this implies is fairly simple: the "no problem" child was basically also a "no problem" child in the family. In some of these same families, however, there were siblings with problems. These mothers consequently spoke about their children with problems when the opportunity occurred during the interview. The "school problem" children were also "problems" in their family. Some of the other children in these families evidently did not have problems at least to the same degree, and possibly, through the focusing of the interview on "problems" and the sample child, there was no consistent opportunity to discuss other children.

The dominance of "physical health" problems is further emphasized through the causes imputed by these mothers to the problems mentioned. Physical influences (the sun, over-exercise, etc., indicating frequently

superstition and "folk" lore) plus physiological troubles were attributed as the "cause" of problems in 61 percent of the interviews with mothers of "school problem" children and in only 12 percent of the interviews with the other mothers.

2. *Sources Used in Seeking Help for Problems:* On the basis of the experiences mentioned by these mothers as they sought help for various things, another fact became apparent:

> Finding: Every family in the two samples had at some time or another sought help from an outside source for one or more reasons.

The preponderance of such contacts was attributed to medical sources such as clinics, hospitals, and physicians. The mothers in the families with "school problem" children reported using more sources than did the other mothers. One of the interesting variations which cannot be explained at this time was in the designation of the source by the mothers in the two samples. Most of the mothers in the "no problem" sample designated their sources in terms of organizational units; for example, "the church" or "the clinic" or "the school." The tendency among the other mothers was to designate a source in terms of individuals: "the teacher" or "the priest" or "the doctor."

a. *A "Special Agency" as a Potential Source of Help:* One of the questions of particular interest for planning purposes was aimed at finding out whether or not these mothers would use an outside source for unusual problems of a non-economic or non-physical nature. Basically, there was little understanding expressed by these mothers of what such a source might be or what it might do.

After a simple explanation of what such an agency might do, only one-fourth of the "no problem" mothers indicated they might use such a source if they really needed help of this kind. The remainder of this sample either gave no answer or qualified their answers with, "Yes, if I had time." or "I haven't needed such help so I really don't know."

The mothers from the "school problem" sample, on the other hand, expressed more interest in such a service and were more prone to indicate that they might use it. Qualifying answers also were given, but these were of different kind: "Yes, if I knew where to go"; "I'm afraid of seeking help"; or "I can't speak English."

The language barrier probably represents a real influence in the seeking and utilization of sources of help for problems.

b. *Contact and Views of the Good Samaritan Center:* Knowledge about a family's contacts with the Good Samaritan Center was obtained usually in a non-directed way. By this is meant the mother spontaneously mentioned the Good Samaritan Center in connection with some topic and also may (or may not) have given her view of the Center. Because of this non-directed approach nothing can be said about the cases which gave no

statement. However, all eight of the mothers of the "no problem" children mentioned that they knew of the Center, and all but one of these actually had used some service offered by the Center. Half of this sample (four mothers) spontaneously gave favorable interpretations of the Center varying from "Wonderful" to "They have done much for us."

Approximately one-third of the mothers of "school problem" children claimed not to have knowledge of the Center or simply didn't mention it in any way. Approximately one-fourth of this sample gave the Center a favorable interpretation.

The most frequently mentioned service used by the families in both samples was medical. The school program ranked second, with a few references to some of the social activities offered by the Center ranking third. Again, the "no problem" mothers referred to the Center as an organization while the "school problem" mothers tended to identify the director of the Center as their reference.

C. Mothers' Views of Child-School Relationships

Another series of questions was asked in each interview concerning the mother's interpretation of the child's school work, hopes and plans for the child, contacts with the school, and so forth. One of the gross differences which emerged when the responses for the two samples were compared was that the mothers of "no problem" children were much freer in expressing opinions and views of the school.

The experience of the children in the two samples did differ concerning their school work. All of the "no problem" children were successful in their first grade school work. Forty-four percent of the "school problem" children had been retained at least once. All but one of the mothers said that her child's attitude toward school before entering the first grade was favorable. One of the "no problem" children and three of the "school problem" children were said by their mothers not to have favorable attitudes toward schools at the time of the interviewing.

Seventy-five percent of the "no problem" mothers were able to express some positive ambition for their child's education; only 18 percent of the mothers of "school problem" children expressed a positive ambition, and the same percentage indicated they either had no goals for their child's education or felt the child wouldn't last long in school anyway.

Few expressions of attitudes toward the school were obtained in the interviews from these mothers. Half of the "no problem" mothers did say they had visited the school and there was no statement about any of these fathers having made such visits. The mothers of the "school problem" children indicated that only 12 percent of them definitely had made school visits, but also 12 percent of them said the father had visited. These latter cases were those in which the mother did not speak English—the substitution of the father was consequently a necessity if the family was to be represented in the school contact.

D. Summary and Projections

From these 24 interviews a rather definite answer can be made to the first major question: "Yes, some kinds of childrens' behavior considered symptomatic of potential mental health disturbance by specialists do bother these mothers." Of first importance in this context ranks somatic problems, which would have to be expanded to include all kinds of physical illnesses. Other problems related to the physiology of the child, such as wetting and masturbation, were also considered to be upsetting.

The personal and social behaviors considered by most mothers to be upsetting were: lack of obedience, shyness and withdrawal, and fighting. The mothers of the "school problem" children in particular tended to ignore the symptomatic behaviors of fears; temper tantrums; fidgeting; shyness; and even masturbation. These same mothers tended to punish more frequently and for more reasons than did the other mothers in the other sample.

The presence of a "no problem" child was not directly indicative of the absence of other children in a family who did have problems. And it was also apparent that the families with a "school problem" child usually did have other kinds of problems and some additional children with problems. The major concerns expressed by the mothers of the "school problem" child families were: (1) physical illness; (2) obedience; and (3) school adjustment, although the third concern is mentioned simply because it did appear—not because it was as widespread as the first two.

Another finding concerning these 24 families was that each had at some time and for some reason sought help from an outside source. In general this is little more than a restatement of the dependency of any social being upon his society. Perhaps the importance of this pattern is rather in the incidence of families which sought outside help only for a few kinds of problems rather than for the whole range of possibilities. A family which takes a sick child to a clinic has sought outside help, but these families evidently did not utilize outside sources of help for many other problems. In a few instances, it was possible to trace a direct referral to a source. One family sought help from a physician about their child's mental condition and was referred to the testing service at Trinity University. The family followed through with this referral.

So many of these mothers suggested that they felt frightened of seeking help and even of going to their child's school that there is another area of inquirey which needs to be explored: the "approachability" of the agencies which might offer service to the citizens in the Good Samaritan neighborhood. Evidently, the Good Samaritan Center has been extremely successful in making itself known as a comfortable place from which to seek help. A few of the other elements in the general pattern are (1) the mothers' inability to converse satisfactorily in English; and (2) their lack of formal education. These two elements in particular might help explain the lack of contacts reported to have occurred between mothers and the

schools their children attend.

An answer to the second question, "Are there other things that these children do which bother the parents in this neighborhood?" cannot be answered so directly on the basis of the interviews. A few statements were obtained concerning this latter question. For example, one mother answered directly that "To fight, to kill, or to get involved with the law" would be a "bad" thing for her child to do. A second mother responded that if her daughter told lies or were to stay out too late at night these would be bad. The third mother who gave a definite answer along these lines stated that if the child were reported by the neighbors as bothering them this would be bad.

But these were isolated answers and a counter-answer was given by other mothers. One laughingly suggested that it would be a wonderful time when her daughter would be old enough to "stay out until all hours." One parent strongly stated that the child had every right to play anywhere in the neighborhood and no one had better complain about it. Another related how the father had spent time teaching the son how to fight, and how proud the father was of the son's victories. Thus it becomes apparent that through these interviews sufficient information was not obtained to explore much beyond these few answers concerning the second question.

The most important finding from this phase of analysis is that these mothers did express concern about their children's health and behavior. They did recognize "symptomatic acts" as being disturbing in many instances, and they did seek help from outside sources for certain kinds of problems--particularly those of health.

SECTION C

HEALTH FACTORS AND FAMILY RELATIONSHIPS

A Descriptive Interpretation –

Some of the Mexican-American children who live in the Good Samaritan Center neighborhood have been described in the preceding sections of this report in terms of their mental and emotional difficulties. But this description is only a small part of the story. What of the families of these children? Mothers and fathers have not only their own difficulties and problems, but also the responsibility for their children with problems. And the difficulties confronting parents may encompass the total range of human needs: mental and emotional; physical; financial; social; interpersonal; and on and on through the whole pattern of life's experiences.

The original objective of this study was not to delve into other than mental and emotional problems of first grade children. But the real interrelationships of parents with their children, and of one kind of problem with another, spontaneously emerged in so many of the interviews with mothers, teachers, and nurses that these additional data could not be ignored. The more rigid analytical process is not applicable to these data, and consequently, we shall attempt to tell the story descriptively. Let us first turn our attention to the families of the 24 first grade children selected for special study (Sample A).

Part I

Problem Children – Who and Why?

A. Family Patterns

In Section B, a distinction was made concerning the families in this sample of 24 children who were, or were not, considered by their teachers to have problems in school adjustment. If we look at the parents and families of these children as they were grouped on the basis of "prob-

lems" and "no problems," several distinct differences emerge. First, we must recall that some other children in the "no problem" group of families had experienced problems in school adjustment, while some other children in the "problem" families had satisfactorily adjusted to school.

But certain factors did emerge in strikingly different ways between these two groups of families:

1. The "no problem" mothers gave many more answers, and more complete answers, than did the mothers of "problem" children.
2. The parents of the "no problem" children were more equal in the responsibility which they shared for their children, with both parents entering into discussions and decision making. Most of the families with "problem" children were father-dominated; many of the remaining were mother-dominated; and one was dominated by a grandparent.
3. Mothers were the chief dispensers of discipline and reward in the "no problem" families; fathers were the more active in the "problem" families.
4. The mothers of the "no problem" children used many different kinds of discipline, and so did their husbands when they administered punishment. There was usually little physical punishment in these patterns. The fathers (and the mothers) of the "problem" families showed less diversity in the kinds of actions used to discipline, and whippings were reported much more frequently, particularly whippings by the father.
5. Following punishment, the children in the "no problem" families regained composure within a short period of time. The majority of children in the "problem" families did not respond well to punishment—they sulked, withdrew, laughed and repeated the act for which punished, etc.

Combining these with other less obvious characteristics, the picture emerged of the "no problem" families as having a more cohesive nature than had the "problem" families. Children were uncontrolled less by the parent in the "no problem" families, and these parents tended to share responsibilities more completely.

One of the unusual forms of punishment mentioned by parents in both groupings was "kneeling." Mothers in particular tended to use this technique which required the child to kneel in a corner or some other out-of-the-way place in order to contemplate this wrongdoing. The basic idea of "kneeling" seems to be derived from a religious orientation. The child kneels before God, seeks forgiveness for the wrongdoing, and then returns to the good graces of the family.

B. External Influences on the Family

One of the traditional patterns for the Mexican-American family is the reliance members of the extended family (even to the third and fourth generations) have upon one another. It possibly is not as common today

as in years past for grandparents to be living in the same house with their children and grandchildren. Only in one family (of a "problem" student) was there a grandparent living as part of the household.

A striking difference does emerge between these two groupings of families when reactions to influences exerted by relatives are examined. As far as could be ascertained in the interviews, the families of the "no problem" children were not disturbed in any way by influences exerted by relatives. More than half of the families of "school problem" children did report that the "wife's relatives" did exert strong influence which created friction.

One possible interpretation of this difference is that the families with the "no problem" children were still united in a satisfactory way with the various generations and relatives. In these families, the parents of the wife are still accorded an important position as symbols of authority, figures whose "ideals" are held to be of great importance in the child rearing practices followed.

Another glimpse into the importance of outside influences is possible through the mothers' statements concerning the degree of control and supervision they maintain over their children. This is another facet of the condition mentioned earlier in this Section. The mothers in these families with the "no problem" children were evidently much more rigorous in either preventing their children from playing outside the house, or in supervising and controlling yard play around the house, than were the mothers of the other group of children.

With lots only 30 feet wide, and sometimes two houses on one lot, as well as in the housing units with their multiple apartments, the pressure of neighbors could be another important influence in the lives of these families. This turns out to be the case for those families with the "school problem" children. These mothers frequently reported intensive contacts with neighbors, frequently of a conflict nature, and also their children were in most instances "roamers" who played over the neighborhood without supervision. The mothers of the "no problem" children, on the other hand, mentioned very few contacts of any sort with neighbors.

One generalization possibly points out the basic distinction between these two groups of families: those with "no problem" children were still acceptably oriented toward relatives and maintained strong family ties; the families with the "school problem" children were less integrated, experienced friction when in interaction with relatives, and relied upon neighbors for many social contacts.

C. Health Problems

Problems of physical health were also much more visible in the families with "school problem" children than in the others. With but one exception, the "school problem" families had one or more members who were suffering from some physical ailment. Almost half of these families had two or more members with a health problem. The "no problem"

families had no current acute illnesses, and only half of them had a history of major illness for some family member.

The parents in the "school problem" families were the ones with the health problems in most instances. The children of the "no problem" families were those members with a history of illness. The illnesses found to be present among the "school problem" families were: polio; extreme nerves; mental illness, diagnosed; asthma; sensory impairment; and combinations of disability and impairment as well as acute illness; cancer; pregnancy difficulties; stomach trouble; and eczema of long duration.

Physical illness, past and current, was present in the lives of the members of the families of the "school problem" children while the "no problem" families had not undergone such suffering and hardships. These fragmented findings are again, only to be taken as suggestions as to the presence and extent of disturbances found to be present in these families. More than this cannot be concluded from this study of this special sample of 24 families.

Part II

As Teachers See Families of School Children

A. Family Disturbances

Spontaneously, as the descriptions of individual children were being obtained from the teachers of the first grade students, (Sample D), information concerning families was also frequently recorded. In 120 instances, information was given which pointed rather clearly to a real difficulty in that family. Some mention of the frequency of broken homes for the parents of this group of children was made in Section A. For these 120 families, information of a more specific nature was obtained concerning family disturbances. Nothing can be concluded about the presence of difficulties and problems for the other families in this group.

In the 120 cases for which data were recorded, a total of 191 difficulties appeared. The distribution of these among five major classifications is as follows:

I.	Disturbed parental relationships	28%
II.	Disturbed parent-child relationships	38%
III.	Parent-social authority conflicts	6%
IV.	Heavy financial problems	14%
V.	Other problems	14%
		100%

Forty-three percent of these 120 families had two distinct difficulties; 16

percent had 3 or more listed.

The disturbances mentioned in connection with parental relationships were: separation (9 cases); constant fighting and quarreling (7 cases); and in lesser numbers, divorce; desertion; mother living with other-than-husband; multiple marriages; death of wife (or husband); father in penitentiary; father never at home; father in hospital.

Teachers identified these strains in certain parent-child relationships known to the teachers: extreme neglect of child (21 cases); child living with other-than-parents (9 cases); plus other strains caused by working mothers who were never at home (6 cases); parents punished too severely; parents over-protected children; too many children for mother to handle; parents rejected children; parents thought child was stupid; parents blamed all their trouble on new baby; child had to stay home from school to take charge of younger siblings; etc.

Eleven instances were reported by the teachers in which they had encountered intentional opposition from parents concerning the child's relationships with the school as an authority. Two cases were known in which the parents refused to recognize the authority of a physician.

Although only a relatively small proportion of this group was mentioned by the teachers as having economic problems (14 percent of the 120 cases), the low income plus large size of families points to more problems than were mentioned. Eight cases were identified as being in desperate financial difficulties; six were known to have only welfare funds as income; 7 had no food, clothes, or supplies; 1 family had no place to live; and so on. The unusual aspect of these interpretations is not the presence of listed cases, but rather the small percentage of the total identified as having financial difficulties. It appears, on the surface at least, that the neighborhood surrounding the Good Samaritan Center is definitely not a slum area, at least in the general sense of a "slum"—no ownership of living units by occupants; run-down houses, yards, and other physically deteriorated conditions; extreme poverty; etc. On the basis of sociological identification, this area would probably be labeled "middle class" according to the standards of the Mexican-American population in general. This labeling is not to be confused with "middle class" as applied to the Anglo-American population, although certain characteristics would be similar.

In the "catch-all" category (Other Problems) were placed family difficulties related to language and culture handicaps (14 cases); siblings in jail; dirty and unclean mothers; paranoid sister in charge of siblings; special problems surrounding an adopted child; and rivalry known in one family over an uncle the same age as the first grade student.

What these "glimpses" do is simply demonstrate the presence of difficulties known to the teachers and point up the need for considering families as dynamic influences upon children. Also, not only are children known to have problems, but these findings represent evidence which may

be used to demonstrate that parents also have difficulties of many different kinds.

B. Health and Related Difficulties

Out of the descriptions obtained for the 120 families, teachers mentioned health and related difficulties as being present for 72 of them. Undoubtedly, families in the remainder of this sample also had problems and difficulties of this kind but these were not known to the teachers.

For these 72 families, a total of 90 difficulties could be enumerated. About one-tenth of all difficulties involved a chronic illness for a parent. Tuberculosis was the most frequently mentioned difficulty, followed by cancer, polio, and hemophilia (uncontrolled bleeding). Eight percent of known difficulties involved a chronic illness in a child. Heart trouble, tuberculosis, and polio dominated this category.

Almost three-fourths of all health difficulties were of a less severe nature. Included here were problems related to malnutrition; difficulty with eyes, teeth, skin; allergies; deformities from birth injuries, accidents, and polio, and several related to severe burns; illness in the stomach or digestive tract; overweight; epileptic; throat trouble; headaches; swollen glands in neck; asthma; adenoids; bladder difficulties; etc.

The final clustering of difficulties was in the mental illness category. Twelve percent of known health difficulties were of this kind. Teachers mentioned one or more cases of the following: suspected mentally ill mother; alcoholic mother; "too nervous" mother; suicidal mother; mentally handicapped child in family; mentally ill child in family; suspected mentally ill father; alcoholic father; and fathers who had been treated for mental illness either in a veterans or state mental hospital.

Only 21 percent of these 72 families were described as having two health difficulties; only 4 percent were said to have 3 or more health difficulties.

The teachers made no mention of any folk ills or cures which have been described by other authorities and the nurses in this particular study.

In all of the discussion relating to these families of first grade children, it must be remembered that the reported incidences are only suggestive as to the magnitude and presence of problems. The interviewing was not conducted in a rigorous way, and only information known to the teachers of these children was obtained. This discussion, therefore, represents only an additional glimpse from a limited source into the difficulties thought to exist in families in the neighborhood of the Good Samaritan Center.

Part III

Glimpses of Families as Known to Public Health Nurses

The third major source of information concerning families in the Good Samaritan neighborhood was derived from discussions with public health nurses concerning families known to them through their nursing service (Sample B). Although approximately 400 cases were discussed, sufficient information was obtained for 128 to permit a fairly extensive discussion (see Appendix A).

First, it should be kept in mind that the health conditions of a family are the primary area of concern for public health nurses. But in visiting and helping families, whether for an illness or through well-baby conferences, nurses gain extremely important insights into family dynamics and characteristics as well.

The families in this special group of 128 had the following characteristics which have also been discussed in Section A: 115 of them had a total of 458 living children. The total number of persons represented by the 128 families was 683. These are the gross figures which the reader may use in making his own interpretations of the following:

The nurses who had served these 128 families described

43 cases of physical illness among children
6 cases of suspected mental illness or deficiency among children
5 cases known to be adjudged delinquent children

54 cases, or approximately 12% of all children

46 cases of physical illness among adults
9 cases of diagnosed or suspected mental illness or deficiency among adults
47 cases of emotional disturbance among adults
8 cases among adults mentioned as having disturbed family relationships
14 cases described for adults where the parent had a social problem

124 cases, or approximately 50% of all adults in these families

A. Physical Illness and Problems

The physical illnesses mentioned for adults were as follows: 12 cases of arrested TB; 9 cases of active TB; 3 cases each of diabetes, severe and continuing headaches, and blindness; and a few cases of hypertension; vaginal infections; abdominal infections; anemia; severely crippled; tumor; deafness; luetic; venereal disease; and lung infection.

The physical illnesses mentioned for children were as follows: 9 cases of crippling deformities; 5 cases of active TB; 8 cases of constant diarrhea; 8 cases of severe malnutrition; and 1 or 2 cases of each of the

following--arrested TB; epilepsy; heart; cerebral palsy; Rx factor; tumor; physically immobile; rheumatoid; hydrocephalic; and 2 children were thought to be handicapped because of premature birth factors.

B. Emotional Difficulties Among Adults

The different difficulties which have been included in this category do not form a compatible grouping, but rather simply indicate a complicated factor which was described for an adult known to the nurses. Here we find 11 cases of women who expressed fears of pregnancy; 10 cases of excessive drinking; 4 cases of sexual maladjustment in marriage; 4 cases of extreme nervousness; and 5 cases lumped together which includes immaturity, extreme fears, etc. The category also includes 13 cases in which the adult expressed fear or suspicion of the health department. Many times these people would hide from the nurse, refuse to go to a clinic, or to permit any one in their family to receive medical service.

Disturbed family relationships were also observed by the nurses with about half of these being "in-law friction" between husband and wife's parents. Two cases of "wife beating" were mentioned, and 2 cases in which the marital partners simply could not adjust to each other were described.

As the final element in "emotional difficulties" these socially conspicuous actions were included: children born before marriage (there is also evidence of a pattern where conception occurred prior to marriage); unwed mothers (6 cases); male had fathered children by other-than-wife; the adult was engaged in dope traffic; a woman who remained naked and in her house all the time; a woman who was a "street-walker;" and a woman who fought constantly with neighbors.

While problems such as these mentioned above are usually identified as "social," the emotional difficulties surrounding such actions and consequences cannot be ignored.

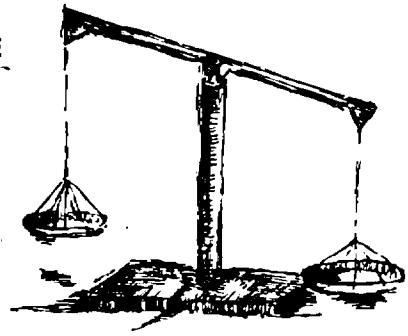
What these listings simply do is to make visible the wide range of difficulties and disturbances present in the personality and life patterns of at least some of the adults who were part of these 128 families.

Conclusions

Perhaps the only safe conclusion which could be inferred from the descriptions presented in this section is that the members of these families did have problems and difficulties of many different kinds. Adults have difficulties; children have difficulties; put together, families have difficulties.

SECTION D

CONSIDERATIONS FOR SERVICE



Based upon the materials presented in this study, certain assumptions may be made which could help in considerations for service which might be developed and extended to the residents in the Good Samaritan Center neighborhood. The actual development of plans is left to those with the responsibility for the life and future of the Center because any decision will involve not only considerable thought and planning but also an evaluation of program, estimates of cost, and questions related to sources of funds and personnel.

A. Assumptions

1. The Good Samaritan Center is known to and accepted by the residents in its neighborhood.
2. The Center's medical clinics are used by approximately 75% of the families in the neighborhood.
3. When mothers are questioned concerning behaviors which are thought by experts to be indicative of future emotional difficulties and mental disturbances, they can identify these behaviors.
4. The Mexican-American mother is deeply and constantly concerned about the health of her children and family.
5. Children in these families do have health problems—physical, as well as mental. One critical point in the developing child is the introduction of the child to public school.
6. Teachers in the neighborhood schools are aware of, and concerned about, the health problems of their students. They also are in many cases aware of family problems and difficulties parents of these children have.
7. The adults in the families in this neighborhood seem to be constantly confronted with many difficulties of a personal, physical, and social nature.
8. One person with a severe difficulty in a family influences other members in that family.

9. The mothers seem to take the primary responsibility for the care and upbringing of children, and are the primary link between the child and health services now present in the neighborhood.
10. Fathers play an important role in determining what the family will do about a problem, if the family is to do anything. The mothers will probably have to actually carry out the action for which the husband has given approval (or agreed to).
11. Family ties, where they exist in a positive way, and favorable friendship ties, serve as strong influences on the residents in this neighborhood. If such ties could be used to bolster parent decisions to seek service, the possibility of bringing a family into service would be increased considerably.
12. The chances of minimizing and of "heading off" mental and emotional problems are greatest among children in this neighborhood.
13. Any service which might be added would have to be set up on a long-range basis with no expectation of demonstrable success within a short time span.

B. *Possible Plan – some combination of the following factors:*

1. Population to be served:
   a. children only
   b. adults only
   c. children, and involved adults
   d. all members of the family needing service
2. Objectives:
   a. preventive (to head off or minimize)
   b. treatment (to utilize one or more current therapy methods in acute cases)
   c. rehabilitative (to help in readjustment following treatment)
   d. educative (to focus on the neighborhood rather than on individual cases)
3. Channels of contact:
   a. regular medical services at Center
   b. special medical services at Center
   c. well-child conferences at Center
   d. day nursery at Center
   e. parent education through Center
   f. rehabilitative services through Center

Any pattern of service would involve the Center's administrative staff in its service, staff, and administrative functions. The relationship between the service structure and the Center would have to be worked out. The relationship of the service structure to other agencies would also have to be worked out.

Ideally, any service which is instituted would have built into its design an evaluation program aimed at measuring the direct effects of the service; the generalized effects; the cost involved; time used; etc.

C. An Example of Planning

As a help to your thinking, let this example serve as reference:

Population to be served: all children, ages 3-7, because all have "problems."

Objective: preventive, to influence development of symptoms primarily through work with parents in socialization.

Channels of contact: any one of the following four—

(1)

Services in Conjunction With or Related to Medical Service

Little Clinic

Advantages	*Disadvantages*
1. Services could be intensive and have, therefore, some measurable results.	1. Initial problem of medical service image, that is referral of only very severe cases.
2. Spanish-speaking personnel already on staff, therefore, the language problem already solved.	2. If traditional clinic procedures, there would be the problem concerning the number of children who could be seen.
3. Problem of maintaining a control group easily handled.	3. Problem of effectiveness of the family with this age group.
4. Has value as demonstration because of likelihood of other medical service centers being able to finance a similar service.	4. Problem of baby sitters.

(2)

Services in Conjunction With or Related to Well Child Conferences

Advantages	*Disadvantages*
1. Well child conferences already are part of Health Department structure and have partial participation of Spanish speaking staff (but would still have problem of getting Spanish-speaking special staff).	1. Would have to start with and work through a nursing staff which has a very limited knowledge of mental health.
2. Attitudes in the community are already favorable to well-child conferences.	2. There would be a problem here of limiting service—this would need to be done to avoid diluting service.
	3. There would be a problem of a control group.

3. Nursing staff already motivated toward mental health.

4. Health Department as a whole is at least accepting of mental health program to some extent.

5. Well-child conference offers positive approach—service to all children rather than very disturbed and very sick.

4. Would have research disadvantage in that unique aspects would be hard to find.

(3)

Services In Conjunction With or Related to Day Nursery Services

Advantages

1. No established traditions about the services to deal with.

2. Possibility of very intensive and continuing service to both mother and child.

3. Would offer possibility of small sample which has the possibility for control.

4. Would offer relief to mothers overburdened with small children.

Disadvantages

1. The big problem—would have to institute a new service.

2. Problem of staffing presents an added dimension—qualified teacher.

3. Limited size of sample possible to use—not a representative sample of population.

4. Problem of people who volunteer—not representative.

(4)

Parent Education for Parents of Three-Year Olds

Advantages

1. Might motivate parents to use services.

2. Can be expanded into every nook and cranny of GSC service to this group.

Disadvantages

1. New service—would have to be set up.

2. It would be dependent upon voluntary use.

3. It would not provide a history for child's problems.

4. It would be difficult to evaluate because of intangible results.

APPENDIX A

Case Selection and Interviewing

The psychologist member of the study team developed the method of case selection for Samples (A), (B), and (D) as follows:

Sample (A): The sample of 24 families was selected on the basis of the material obtained from the public schools serving the area. In developing Sample (D), teachers described children in the first grade to interviewers who determined on the basis of the interview whether or not the children were showing disturbed behavior in the classroom. The teachers also indicated their opinion as to whether or not the parents were aware of their child's problems. For the purpose of this special part of the study, eight children were selected who were rated as having mental health problems of which their parents were aware; eight children were selected who were rated as having mental health problems of which their parents were unaware; and eight children were selected who had not demonstrated any behavior problems in the school setting. These children were selected to represent major categories of behavior disturbance on a random basis.

An interview schedule was prepared with the co-operation of the Spanish-speaking interviewers who were familiar with the people in the area and pretested in an adjacent area of similar socio-economic and cultural composition.

On the basis of knowledge of people experienced in this cultural area, it was decided that an interview of some depth might be conducted with Spanish-speaking mothers. Several prerequisites for a successful interview were established. Interviewers were to be fluent in the language spoken by the interviewees. Because the interviews were to be with mothers in their homes, women interviewers were essential. Finally, rapport could be more easily established with people already known in this area, such as public health nurses. Through the co-operation of the San Antonio Health Department, two senior public health nurses were designated to do the interviewing. The interviewers, after a two-day period of intensive training in interviewing techniques, proceeded with their interviews.

When visited, mothers without fail received the nurses warmly and openly. There were a few cases in which the mothers were initially apprehensive; however, their apprehension seemed to pass quickly. Initially, interviewers were concerned about going into a home for the first time and asking many questions. However, they found no expression of resentment by the mothers, and they frequently were asked to return if in any way their return would be helpful. One of the difficul-

ties in carrying out these interviews was that in many homes a large number of the family was present during the interview. There seemed, however, to be no reluctance, on the part of the mothers to give information, and the nurses had the impression that there was little tendency to dissemble. The nurses had the general impression that many times the mother had not given a particular problem under discussion much thought even though she was aware of the problem.

The nurses attempted to record verbatim during the interviews. However, despite the fact that the nurses wrote during the interview a certain amount of distortion was inevitable because of the problem of translation from Spanish. The interviews were typed.

Sample (B): The psychologist and the psychiatric social worker interviewed the five public health nurses who were serving families in the Good Samaritan Center neighborhood. They asked the nurses to describe each case in their records where the family was resident in this particular neighborhood.

First, the nurses were asked to read the same instructions used with the teachers to be described in conjunction with Sample (D). Then the nurse briefly described each family, pointing out any problems she considered to be of mental health significance. Whenever there was some doubt as to the nature of the problem, the interviewer requested more detail which would make possible a judgment of the mental health rating of the family. Of the nearly 600 families known to the public health nurses, 383 families comprising the complete caseloads of four nurses and a small part of the fifth nurse's cases were reviewed. Later, the Director of the Center completed the interview with the fifth nurse bringing the total number of cases discussed to 399.

The nurses co-operated completely and, apparently, felt little discomfort in this task. The interviewer alone rated the family. Information of the extended type discussed in this study was obtained by one interviewer for 128 of these cases. It is this latter sub-sample which comprises the basic data used for the description of difficulties as seen by the nurses.

Sample (C): The Director of the Center reviewed the records maintained by the clinics at the Good Samaritan Center for the first three months of 1960. These records revealed services had been extended to members of 160 different family units. Special discussions and interviews were also conducted by the Director to augment other phases of the study as it progressed.

Sample (D): In order to obtain a sampling of the mental health problems in the Good Samaritan Center area, a review was made of the adjustment of the first grade children from the two elementary schools in the area. This decision was based upon these assumptions:

1. The children in the first grade would be representative of all types of families in the area.

2. First grade children reveal in their early school adjustment problems which have previously developed in family living.
3. Behavior of first grade children reflects reactions to their first major encounter with conflict between standards of home and school cultures.
4. Teachers of first grade children know their pupils and their families better than teachers of other grades and are especially sensitive to their needs.
5. Teachers of first grade children could provide information helpful in identifying evidences of mental health strength and stress.

Each of the two elementary public schools had eight first grade teachers and a total of 482 first grade children. Only about 40 first grade children were enrolled in parochial schools and so no attempt was made to include them in the sample. Twelve of the teachers were Anglo-American and four were of Mexican-American descent.

Each teacher had been asked by the principal to bring her class roll to the interview which lasted for an hour. The interviewers were the psychiatric social worker and the psychologist of the study team, both consultants for the State Department of Health, Division of Mental Health. After the instructions were read, the categories to be used in categorizing children's behavior were explained for use as a frame of reference. These were adapted from a series developed by Maholick and Shapiro.[1] Each teacher was told that these categories were to be regarded as suggestive, rather than as a check-list, and that a thumbnail description of each child as a person was really what was desired. Emphasis was placed upon the fact that she was not expected to make a diagnostic statement about any child.

Categories

Mental deficiency
Severe conduct disturbance
Special symptom reaction
Severe emotional distress
Psychosomatic problems
Suspected mental illness
Other, psychiatric service recommended
Lack of adjustment to peers [2]
Immaturity [2]
No problem [2]

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[1] Leonard T. Maholick, M.D., and David S. Shapiro, Ph.D. A Survey of Unmet Needs for Psychiatric, Psychological and Social Services in an Urban Community.

[2] Further categories added by interviewers for clarification of problem.

Teachers and principals were interested in cooperating in this way. They knew that their work in the school was not to be evaluated in any way; that their purpose in helping identify needs of children in the area was directed toward expanding Good Samaritan Center services. These interviews were focused on the mental health of the children. With a minimum of direction, teachers were able to give significant mental health information in their short thumbnail descriptions of children.

After the completion of all interviews, classification of problems was made by three professional people.

APPENDIX B

Bibliography of Related Studies

A. *Texas Studies*

There are relatively few studies concerned with the health problems of the Mexican-Americans in Texas and in this nation. One detailed study of health problems among migratory workers, which has as yet not been released to the public, was completed in September, 1960. Dr. Eugene Gutherie, Helen Johnston, and Bill Yanniello, of the United States Public Health Service, conducted the study which in preliminary draft carries the title: "Texas-Michigan Public Health Service, Migrant Health Project." Starting with physical examinations in Laredo for 141 migrant workers, the study follows these persons on their work route up to Michigan and back to Texas. Several cases involving "caida de la mollera" (fallen frontenela) and "mal ojo" (evil eye) are recorded in this report.

Sister Frances Jerome Woods, of Our Lady of the Lake College, San Antonio, delves particularly into the relationship of Mexican-American culture and mental health in her article: "Cultural Conditioning and Mental Health," Social Casework, Volume 39, Number 6 (June, 1958) pp. 327-333. There is much valuable information here concerning the Mexican-Americans, their culture, and mental health problems in San Antonio.

An outstanding study of the Mexican-American culture and health problems in Texas has been developed by William Madsen and his staff. Their preliminary report, "Society and Health in the Lower Rio Grande Valley," was presented to the public health officials in Hidalgo County in July, 1961. This study was supported primarily by the Hogg Foundation for Mental Health, The University of Texas, Austin. Dr. Madsen is with the Department of Anthropology, The University of Texas. Two articles which reflect other findings from this project are: Arthur J. Rubel, "Concepts of Disease in Mexican-American Culture," American Anthropologist, Volume 62, Number 5 (October, 1960) pp. 795-814; and Octavio Ignacio Romano

V, "Donship in a Mexican-American Community in Texas," American Anthropologist, Volume 62, Number 6 (December, 1960) pp. 966-976.

An earlier study of a South Texas community was conducted by Ozzie G. Simmons in 1950. An article describing some of the elements he found to be present in the Mexican-American culture is: "The Mutual Images and Expectations of Anglo-Americans and Mexican-Americans," Daedalus (Spring, 1961) pp. 286-299. Simmons emphasizes the inconsistencies which exist in the understanding (and assumptions) that Anglo-and Mexican-Americans hold for each other. He identifies as a problem area the desire of the Mexican-Americans to be accorded equal status in the larger society even though they do not wish to give up their traditional ways. His complete study of this community is: *Anglo-Americans and Mexican-Americans in South Texas: A Study in Dominant- Subordinate Group Relations*, (unpublished dissertation, Harvard University, 1952.)

E. Gartly Jaco is the one researcher who has studied intensively the incidence of psychosis among Mexican-Americans in Texas. In two articles, he describes the differences among Anglo-, Negro-, and Mexican-Americans in relation to mental illness: "Social Factors in Mental Disorders in Texas," Social Problems, Volume 4 Number 4 (April, 1957) pp. 322-328; and "Mental Health of the Spanish-American in Texas" in *Culture and Mental Health* (Ed. Marvin K. Opler), (New York: The MacMillan Company, 1959), pp. 476-477.

B. *Studies from Other States*

Lyle Saunders, in two publications, presents an exceedingly comprehensive picture of health, medical care, and differences between Anglo- and Mexican-American groups. These fascinating inquiries are: *Cultural Differences and Medical Care*, Russell Sage Foundation, New York, 1954; and "Anglos and Spanish-Speaking: Contrasts and Similarities," University of Colorado School of Medicine, 1959.

An extremely comprehensive study which combines an examination of the Mexican-American culture in transition with specific concern for health problems is available, by: Margaret Clark, *Health in the Mexican-American Culture*, University of California Press, Los Angeles, California, 1959. Her thesis, which is admirably demonstrated, is that one cannot understand patterns of health, sickness, *and* treatment unless one understands the cultural values, superstitions, and folk practices which exist and influence people in the culture-group. Although the study was conducted in California, the findings are extremely similar to those which have been developed in Texas, New Mexico, and Colorado studies.

From New Mexico come these additional interesting reports: Myron S. Eidenson, *Los Manitos: A Study of Institutional Values*, Tulane University, New Orleans, 1957. The second is an article by Sam Schulman: "Rural Healthways in New Mexico," *Culture, Society, and Health*, Annals of the New York Academy of Sciences, Volume 84 (December, 1960) 950-958.

The third report is unique among all of the studies described in this bibliography because a psychiatrist, Dr. Rudolph Kieve, has turned his attention to "The Meaning and Use of Illness and Disability among Spanish-Speaking People in Northern New Mexico." His report was presented at the Fourth Western Divisional Meeting of the American Psychiatric Association, Salt Lake City, Utah, September 21, 1961, and so far is available only upon request from the author. This study is a "must" for anyone who seeks to gain adequate comprehension of health and illness among Mexican-Americans.

The final report in this section is entitled "Medical Vocabulary Knowledge Among Hospital Patients," by Julian Samora, Lyle Saunders, and Richard F. Larson. The problems of communication, understanding, and cultural differences among Anglo-American medical persons and Mexican-American patients are discussed in this paper which appeared in the Journal of Health and Human Behavior, Volume II, Number 2 (Summer, 1961) pp. 83-92.

C. *Studies from Mexico and other Latin American Countries*

There are a number of studies currently available which focus upon health and culture of Mexico and other Latin American countries. Three major works describe the modern Mexican culture in transition, much of which is also visible to some extent in the cultural changes occurring on the northern side of the Rio Grande as well. These studies are: Oscar Lewis, *Five Families*, Basic Books, New York, 1959; and a sequel by the same author, *Children of Sanchez*, Basic Books, New York, 1961. The third study brings attention again to William Madsen with his recent book: *The Virgin's Children: Life in An Aztec Village Today*, The University of Texas Press, Austin, 1960.

Under the editorship of George Foster, the Smithsonian Institution released a special study in 1951 of the health services provided through technical aid programs in a number of Latin American countries, including Mexico. The title of this report is: "A Cross-Cultural Anthropological Analysis of a Technical Aid Program." Isabel Kelly performed the study in Mexico, and others on this project in different countries were: Charles Erasmus, Ozzie Simmons, and Kalervo Oberg.

Lloyd H. Rogler and August B. Hollingshead recently published a study of "The Puerto Rican Spiritualist as a Psychiatrist," in The American Journal of Sociology, Volume 67, Number 1 (July, 1961) pp. 17-21. Fascinating glimpses of the Latin American's fears, superstitions, and thinking about mental illness and health are presented here.

The final two studies provide information concerning the rural culture in modern Mexico. Kenneth J. Cooper describes "Rural-Urban Differences in Responses to Field Techniques" in the journal, Human Organization, Volume 18, Number 3 (Fall, 1959) pp. 135-139. The settings for his comparative study of communication, meaning, and research difficulties, are two rural villages in the state of Morelos, and a selected portion of Mexi-

co City. T. Lynn Smith, an outstanding rural sociologist who, perhaps more than any other sociologist, has contributed to the understanding of rural Latin America, condenses much of his knowledge about rural culture in the article: "The Rural Community with Special Reference to Latin America," in Rural Sociology, Volume 23, Number 1 (March, 1958) pp. 52-67.

These various studies and reports contain a wealth of information about the Mexican-American, his culture, health concepts and problems, treatment techniques including descriptions of folk-medicine, family patterns, and the changes which are occurring as urbanization increases bringing with it technological advances in most fields including medicine. Against this background, *The Forgotten Egg* will take on new meaning for the reader who is interested in the sources of and meanings behind, what we discuss in our study of one small, recently settled, urban neighborhood.